

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 784

Primary Registration District No. 109

Registrar's No. 2011

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Marine Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 35 days
In this community Unknown (Specify whether years, months or days)

8. (a) PRINT FULL NAME George L. Watts

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ruth Watts 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased July 25 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months 2 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer

11. Industry or business Steamer Iowa - St. Louis, Mo

12. Name James Watts

13. Birthplace Missouri Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Emma Harvey Missouri
(City, town, or county) (State or foreign country)

15. Birthplace _____

16. (a) Informant Clinical records of hospital

(b) Address St. Louis Marine Hosp., Kirkwood, Mo

17. (a) Burial (b) Date thereof Oct 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Osman G. Hymowitz

(b) Address 4016 Chippewa

19. (a) OCT 24 1940 (b) TR [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County X
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4061 Gravois Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22nd
year 1940 hour Five minute A M

21. I hereby certify that I attended the deceased from September 17th, 1940, to October 22nd, 1940;

that I last saw him alive on October 21st, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage cerebral 27 days

Due to 8221
Due to _____

Other conditions Fistula-biliary 30 days
(Include pregnancy within 5 months of death)

Major findings: None PHYSICIAN
Of operations _____

Of autopsy None
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence X

(c) Where did injury occur? X
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Marine Hospital, Kirkwood, Mo Date signed 10/22/40

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed: _____

Ernest W. Spillers

Licensed Embalmer No. _____

4080

P. O., Address _____

3747 Dunnic

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.